Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

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Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 3—Conditions of Provider Participation, Reimbursement and Procedure of General Applicability

13 CSR 70-3.020 Title XIX Provider Enrollment

PURPOSE: This rule establishes the basis on which providers and vendors of health care services under Title XIX Medicaid Programs may be admitted to or denied enrollment in the program and lists the grounds upon which enrollment may be denied.

(1) The following definitions will be used in administering this rule:

(A) Affiliates—Persons having an overt, covert or conspiratorial relationship so that any one of them directly or indirectly controls or has the power to control another;

(B) Applying provider—Any person who has submitted an application or request for enrollment in the Missouri Title XIX Medicaid Program;

(C) Closed-end provider agreement—An agreement that is for a specific period of time not to exceed twelve (12) months and that must be renewed in order for the provider to continue to participate in the Medicaid program.

(D) Fiscal agent—An organization under contract to the state Medicaid agency for providing services in the administration of the Medicaid program;

(E) Limited provider agreement—The granting of Medicaid enrollment to an applying provider by the single state agency upon the condition that the applying provider perform services, deliver supplies or otherwise participate in the program only in adherence to or subject to specially set out conditions agreed to by the applying provider prior to enrollment;

(F) Medicaid agency or the agency—The single state agency administering or supervising the administration of a state Medicaid plan;

(G) Open-end provider agreement—An agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

(H) Participation—The ability and authority to provide services or merchandise to eligible Medicaid recipients and to receive payment from the Medicaid program for the services or merchandise;

(I) Provider—Any person having an effective, valid and current written provider agreement with the Medicaid agency for the purpose of providing services to eligible recipients and obtaining reimbursement excluding, for the purposes of this rule only, all persons receiving reimbursement in their capacity as owners or operators of a licensed nursing home;

(J) Provider enrollment application—A signed writing utilizing forms specified by the single state agency, containing all applicable information requested and submitted by a provider of medical assistance services for the purpose of enrolling in the Missouri Title XIX Medical Assistance Program;

(K) Person—Any natural person, partnership, corporation, not-for-profit corporation, professional corporation or other business entity;

(L) Termination from participation—The ending of participation in the Medicaid program; and

(2) Duties of the Single State Agency.

(A) Upon receiving a provider enrollment application, the single state agency shall record receipt of the application and conduct whatever lawful investigation which, in the discretion of the Medicaid agency, is necessary to verify, supplement or change the information contained in the application.

(B) If, in the discretion of the Medicaid agency, further information is needed from the applying provider to verify or supplement an application, the Medicaid agency shall immediately make a clear and precise request to the provider for the information and inform the prospective provider whether or not the application will be withheld pending receipt of the requested information.

(C) The single state agency, within ninety (90) calendar days after receiving an application, shall complete its investigation and determine whether to deny or allow enrollment of the applying provider. The Medicaid agency's decision shall be made known to the applying provider within ninety-five (95) calendar days after the application was received by the agency. A denial of enrollment shall be made known to an applying provider giving the reason(s) for the denial in writing. The written notice of denial will be effective upon the date it is mailed by the single state agency to the address entered on the application by the provider.

(D) In the event that an application cannot be fully investigated by the single state agency within ninety (90) days of its receipt, the Medicaid agency, upon written notice to the applying provider, may extend the time for conducting the investigation for a period not to exceed one hundred twenty (120) calendar days from the date of receipt of the application by the Medicaid agency. The Medicaid agency must send the notice of delay to the applying provider within sixty (60) calendar days from the time the application in question was received.

(3) The single state agency, at its discretion, may deny or limit an applying provider's enrollment and participation in the Missouri Title XIX Medicaid Program for any one (1) of the following reasons:

(A) A false representation or omission of any material fact or information required or requested by the single state agency pursuant to an applying provider making application to enroll. This shall include material facts or omissions about previous Medicaid participation in Missouri or any other state of the United States;

(B) Previous or current involuntary surrender, removal, termination, suspension, ineligibility or otherwise involuntary disqualification of the applying provider's Medicaid participation in Missouri or any other state of the United States;

(C) Previous or current involuntary surrender, removal, termination, suspension or otherwise involuntary disqualification from participation in Medicare;

(D) Previous or current involuntary surrender, removal, termination, suspension, ineligibility or otherwise involuntary disqualification from participation in another governmental or private medical insurance program. This includes, but is not limited to, Workers' Compensation, Crippled Children's Services and Rehabilitation Services. For the purposes of subsections (3)(B)–(D), involuntary surrender, removal, termination, suspension, ineligibility or other involuntary disqualification shall include withdrawal from medical assistance or medical insurance program participation arising from or as a result of any adverse action by a government agency, licensing authority or criminal prosecution authority of Missouri or any other state or the federal government including Medicare;

(E) The existence of any amount due the single state agency which is the result of an overpayment under the Missouri Title XIX Medicaid Program of which the applying provider has had notice. Any amount due which is the subject of a plan of restitution shall not be considered in applying this section unless the applying provider is in default of the plan of restitution in which case enrollment may be denied or limited;

(F) Previous or current conviction of any crime relating to the applying provider's professional, business or past participation in

Medicaid, Medicare or any other public or private medical insurance program;

(G) Any civil or criminal fraud against the Missouri Medicaid program or any other public or private medical insurance program;

(H) Any termination, removal, suspension, revocation, denial or consented surrender or other involuntary disqualification of any license, permit, certificate or registration related to the applying provider's business or profession in Missouri or any other state of the United States. Any such license, permit, certificate or registration which has been denied or lost by the provider for reasons not related to matters of professional competence in the practice of the applying provider's profession, upon proof of current reinstatement, shall not be considered by the agency in its decision to enroll the applying providers;

(I) Any false representation or omission of a material fact in making application for any license, permit, certificate or registration related to the applying provider's profession or business in Missouri or any other state of the United States;

(J) Any previous failure to correct deficiencies in provider operation after receiving written notice of the deficiencies from the single state agency;

(K) Any previous violation of any regulation or statute relating to the applying provider's participation in the Missouri Medicaid program;

(L) Failure to supply further information to the single state agency after receiving a written request for further information pursuant to an enrollment application; or

(M) Failure to affix a proper signature to an enrollment application. Submission of an application bearing a signature that conceals the involvement in the provider's operation of a person who would otherwise be ineligible for Medicaid participation shall be grounds for denial of enrollment by the single state agency. Otherwise, the single state agency shall give the applying provider an opportunity to provide a proper signature and, after that, consider the application as if the proper signature was originally affixed.

(4) After investigation and review of an applying provider's application for enrollment and consideration of all the information, facts and circumstances relevant to the application, including, but not limited to, a review of the applying provider's affiliates, the single state agency, at its discretion, in the best interest of the Medicaid program, will make one (1) of the following determinations:

(A) Enroll the applying provider in an open-ended provider agreement;

(B) Deny or limit the application of an applying provider based on the abuse, fraud or deficiencies of an affiliate, provided that each decision to deny or limit is based on a case-by-case evaluation, taking into consideration all relevant facts and circumstances known to the single state agency. The program abuse, fraud, regulatory violation or deficiencies of a past or present affiliate of an applying provider may be imputed to the applying provider where the conduct of a past or present affiliate was accomplished with the knowledge or approval of the applying provider; or

(C) Deny or limit the applying provider's enrollment for one (1) or more of the reasons in subsections (3)(A)–(M).

(5) Denial of enrollment shall preclude any person from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, affiliate, partner or any other association to the single state agency or its fiscal agents for any services or supplies delivered under the Medicaid program whose enrollment as a Medicaid provider has been denied. Any claims submitted by a nonprovider through any clinic, group, corporation, affiliate, partner or any other association and paid shall constitute overpayments.

(6) No clinic, group, corporation, partnership, affiliate or other association may submit claims for payment to the single state agency or its fiscal agent for any services or supplies provided by a person within each association who has been denied enrollment in the Medicaid program. Any claims for payment submitted and paid under these circumstances shall constitute overpayments.

AUTHORITY: sections 207.020, RSMo Supp. 1993, 208.159, RSMo 1986 and 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.165. Original rule filed June 14, 1982, effective Sept. 11, 1982.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.159, RSMo 1970.*

13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services

PURPOSE: This rule establishes the basis on which certain claims for Title XIX services or merchandise will be determined to be false or fraudulent and lists the sanctions which may be imposed and the method of imposing those sanctions.

(1) The following definitions will be used in administering this rule:

(A) Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Adequate medical records are records which are of the type and in a form from which symptoms, conditions, diagnosis, treatments, prognosis and the identity of the patient to which these things relate can be readily discerned and verified with reasonable certainty. All documentation must be made available at the same site at which the service was rendered.

(B) Affiliates means persons having an overt, covert or conspiratorial relationship so that any one (1) of them directly or indirectly controls or has the power to control another;

(C) Closed-end provider agreement means an agreement that is for a specified period of time, not to exceed twelve (12) months, and that must be renewed in order for the provider to continue to participate in the Medicaid program;

(D) Fiscal agent means an organization under contract to the state Medicaid agency for providing any services in the administration of the Medicaid program;

(E) Medicaid agency or the agency means the single state agency administering or supervising the administration of a state Medicaid plan;

(F) Open-end provider agreement means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties;

(G) Participation means the ability and authority to provide services or merchandise to eligible Medicaid recipients and to receive payment from the Medicaid program or those services or merchandise;

(H) Person means any natural person, company, firm, partnership, unincorporated association, corporation or other legal entity;

(I) Provider means an individual, firm, corporation, pharmacy, hospital, long-term care facility, association or institution which has a provider agreement to provide services to a recipient pursuant to Chapter 208, RSMo;

(J) Records means any books, papers, journals, charts, treatment histories, medical histories, tests and laboratory results, photographs, X rays and any other recordings of data or information made by or caused to be made by a provider relating in any way to services provided to Medicaid recipients and payments charged or received. Medicaid claim for payment information appointment books, financial ledgers, financial journals or

any other kind of patient charge without corresponding adequate medical records do not constitute adequate documentation;

(K) Supervision means the service was performed while the provider was physically present during the service or the provider was on the premises and readily available to give direction to the person actually performing the service;

(L) Suspension from participation means an exclusion from participation for a specified period of time;

(M) Suspension of payments means placement of payments due a provider in an escrow account;

(N) Termination from participation means the ending of participation in the Medicaid program; and

(O) Withholding of payments means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

(2) Program Violations.

(A) Sanctions may be imposed by the Medicaid agency against a provider for any one (1) or more of the following reasons:

1. Presenting, or causing to be presented, for payment any false or fraudulent claim for services or merchandise in the course of business related to Medicaid;

2. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is entitled under applicable Medicaid program policies or rules, including, but not limited to, the billing or coding of services which results in payments in excess of the fee schedule for the service actually provided or billing or coding of services which results in payments in excess of the provider's charges to the general public for the same services, or altering or falsifying medical records to obtain or verify a greater payment than authorized by a fee schedule or reimbursement plan;

3. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements or for the purpose of obtaining payments in order to avoid the effect of those changes;

4. Making available, and disclosing to the Medicaid agency or its authorized agents, all records relating to services provided to Medicaid recipients and Medicaid payments, whether or not the records are commingled with non-Title XIX records is mandatory for all providers. Copies of records must be provided upon request of the Medicaid agency or its authorized agents. Failure to make these records available on a timely basis at the same site at which the services were rendered, or failure to provide copies as requested, or failure to keep and make available adequate records which adequately document the services and payments shall constitute a violation of this section and shall be a reason for sanction;

5. Failing to provide and maintain quality, necessary and appropriate services, including adequate staffing for long-term care facility Medicaid recipients, within accepted medical community standards as adjudged by a body of peers, as set forth in both federal and state statutes or regulations. Failure shall be documented by repeat discrepancies. The discrepancies may be determined by a peer review committee, medical review teams, independent professional review teams, utilization review committees or by Professional Standards Review Organizations (PSRO). The medical review may be conducted by qualified peers employed by the single state agency;

6. Engaging in conduct or performing an act deemed improper or abusive of the Medicaid program or continuing the conduct following notification that the conduct should cease. This will include inappropriate or improper actions relating to the management of recipients' personal funds or other funds;

7. Breaching of the terms of the Medicaid provider agreement of any current written and published policies and procedures of the Medicaid program (such as are contained in provider manuals or bulletins) or failing to comply with the terms of the provider certification on the Medicaid claim form;

8. Utilizing or abusing the Medicaid program as evidenced by a documented pattern of inducing, furnishing or otherwise causing a recipient to receive services or merchandise not otherwise required or requested by the recipient, attending physician or appropriate utilization review team; a documented pattern of performing and billing tests, examinations, patient visits, surgeries, drugs or merchandise that exceed limits or frequencies determined by the department for like practitioners for which there is no demonstrable need, or for which the provider has created the need through ineffective services or merchandise previously rendered;

9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral; or collecting a portion of the service fee from the recipient, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

10. Violating any provision of the State Medical Assistance Act or any corresponding rule;

11. Submitting a false or fraudulent application for provider status which misrepresents material facts. This shall include concealment or misrepresentation of material facts required on any provider agreements or questionnaires submitted by affiliates when the provider knew or should have known the contents of the submitted documents;

12. Violating any laws, regulations or code of ethics governing the conduct of occupations or professions or regulated industries. In addition to all other laws which would commonly be understood to govern or regulate the conduct of occupations, professions or regulated industries, this provision shall include any violations of the civil or criminal laws of the United States, of Missouri or any other state or territory, where the violation is reasonably related to the provider's qualifications, functions or duties in any licensed or regulated profession or where an element of the violation is fraud, dishonesty, moral turpitude or an act of violence;

13. Failing to meet standards required by state or federal law for participation (for example licensure);

14. Excluding from Medicare for any reason arising out of improper conduct related to the Medicare program;

15. Failing to accept Medicaid payment as payment in full for covered services or collecting additional payment from a recipient or responsible person, except this shall not apply to Title XIX services for which recipients are responsible for payment of a copayment or coinsurance in accordance with 13 CSR 70-4.051 and 13 CSR 70-55.010;

16. Refusing to execute a new provider agreement when requested to do so by the single state agency in order to preserve the single state agency's compliance with federal and state requirements; or failure to execute an agreement within twenty (20) days for compliance purposes;

17. Failing to correct deficiencies in provider operations within ten (10) days after receiving written notice established by a signed receipt of delivery of these deficiencies from the single state agency or within the time frame provided from any other agency having licensing or certification authority;

18. Being formally reprimanded or censured by a board of licensure or an association of the provider's peers for unethical, unlawful or unprofessional conduct; any termination, removal, suspension, revocation, denial, probation, consented surrender or other disqualification of all or part of any license, permit, certificate or registration

related to the provider's business or profession in Missouri or any other state or territory of the United States;

19. Being suspended or terminated from participation in another governmental medical program such as Workers' Compensation, Crippled Children's Services, Rehabilitation Services and Medicare;

20. Using fraudulent billing practices arising from billings to third parties for costs of services or merchandise or for negligent practice resulting in death or injury or substandard care to persons including, but not limited to, the provider's patients;

21. Failing to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments prior to the allowed forty-five (45) days which the provider has to refund the requested amount;

22. Billing the Medicaid program twice for the same service when the billings were not caused by the single state agency or its agents;

23. Billing the state Medicaid program for services not provided prior to the date of billing (prebilling), except in the case of prepaid health plans or pharmacy claims submitted by point-of-service technology; whether or not the prebilling causes loss or harm to the Medicaid program;

24. Failing to reverse any pharmacy claims submitted by point-to-service technology, while representing services not received by the recipient, by the time established by pharmacy manual on the Friday evening following the date the claim was submitted by point-of-service technology.

25. Conducting any action resulting in a reduction or depletion of a long-term care facility Medicaid recipient's personal funds or reserve account, unless specifically authorized in writing by the recipient, relative or responsible person;

26. Providing services by a nonenrolled person without the direct supervision of a provider and billed by the provider as having performed those services, or services billed by a provider but performed by a similarly licensed practitioner, nonenrolled due to Medicaid sanction, whether or not the performing practitioner was under supervision of the billing provider;

27. Making any payment to any person in return for referring an individual to the provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid. Soliciting or receiving any payment from any person in return for referring an individual to another supplier of goods or services regardless of whether the supplier is a Medicaid provider for the delivery of any goods or services for which payment may be made in whole or in part under Medicaid is also prohibited. Payment includes, without limitation, any kickback, bribe or rebate made, either directly or indirectly, in cash or in-kind;

28. Having services billed and rendered which were upgraded from those actually ordered or billing or coding services in a manner that services are paid for as separate procedures when, in fact, the services were performed concurrently or sequentially and should have been billed or coded as integral components of a total service as prescribed in Medicaid policy for payment in a total payment less than the aggregate of the improperly separated services;

29. Conducting civil or criminal fraud against the Missouri Medicaid program or any other state Medicaid (medical assistance) program, or any criminal fraud related to the conduct of the provider's profession or business;

30. Having sanctions or any other adverse action invoked by another state Medicaid program;

31. Failing to take reasonable measures to review claims for payment for accuracy, duplication or other errors caused or committed by employees when the failure allows material errors in billing to occur. This includes failure to review remittance advice statements provided with the payment document which results in payments which do not correspond with the actual services rendered;

32. Submitting improper or false claims to the state or its fiscal agent by an agent or employee of the provider;

33. Failing to retain worksheets or other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be retained for five (5) years. Long-term care providers are required to retain financial records for seven (7) years;

34. Removing or coercing from the possession or control of a recipient any item of durable medical equipment which has reached Medicaid-defined purchase price through Medicaid rental payments or otherwise become the property of the recipient without paying fair market value to the recipient;

35. Failing to timely submit civil rights compliance data or information or failure to timely take corrective action for civil rights compliance deficiencies within thirty (30) days after notification of these deficiencies or failure to cooperate or supply information required or requested by civil rights compliance officers of the single state agency; and

36. Billing the Medicaid program for services rendered to a recipient in a long-term care facility when the resident resided in a portion of the facility which was not Medicaid-certified or properly licensed or was placed in a nonlicensed or Medicaid-noncertified bed.

(3) Any one (1) or more of the following sanctions may be invoked against providers for any one (1) or more of the program violations specified in section (2) of this rule:

(A) Failure to respond to notice of overpayments or notice of deficiencies in provider operations within the specified forty-five (45)-day time limit shall be considered cause to withhold future provider payments until the situation in question is resolved;

(B) Termination from participation in the Medicaid program for a period of not less than sixty (60) days nor more than ten (10) years;

(C) Suspension of participation in the Medicaid program for a specified period of time;

(D) Suspension or withholding of payments to a provider;

(E) Referral to peer review committees including PSROs or utilization review committees;

(F) Recoupment from future provider payments;

(G) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement;

(H) Attendance at provider education sessions;

(I) Prior authorization of services;

(J) One hundred percent (100%) review of the provider's claims prior to payment;

(K) Referral to the state licensing board for investigation;

(L) Referral to appropriate federal or state legal agency for investigation, prosecution, or both, under applicable federal and state laws;

(M) Retroactive denial of payments; and

(N) Denial of payment for any new admission to a skilled nursing facility (SNF), intermediate care facility (ICF) or ICF/mentally retarded (MR) that no longer meets the applicable conditions of participation (for SNFs) or standards (for ICFs and ICF/MRs) if the facility's deficiencies do not pose immediate jeopardy to patients' health and safety. Imposition of this sanction must be in accordance with all applicable federal statutes and regulations.

(4) Imposition of a Sanction.

(A) The decision as to the sanction to be imposed shall be at the discretion of the Medicaid agency. The following factors shall be considered in determining the sanction(s) to be imposed:

1. Seriousness of the offense(s) The state agency shall consider the seriousness of the offense(s) including, but not limited to, whether or not an overpayment (that is, financial harm) occurred to the program, whether substandard services were rendered to Medicaid recipients, or circumstances were such that the provider's behavior could have caused or contributed to inadequate or dangerous medical care for any patient(s), or a combination of these. Violation of pharmacy laws or rules, practices potentially dangerous to patients and fraud are to be considered particularly serious;

2. Extent of violations The state Medicaid agency shall consider the extent of the violations as measured by, but not limited to, the number of patients involved, the number of Medicaid claims involved, the number of dollars identified in any overpayment and the length of time over which the violations occurred. The Medicaid agency may calculate an overpayment or impose sanctions under this rule by reviewing records pertaining to all or part of a provider's Medicaid claims. When records are examined pertaining to part of a provider's Medicaid claims, no random selection process in choosing the claims for review as set forth in 13 CSR 70-3.130 need be utilized by the Medicaid agency. But, if the random selection process is not used, the Medicaid agency may not construe violations found in the partial review to be an indication that the extent of the violations in any unreviewed claims would exist to the same or greater extent;

3. History of prior violations The state agency shall consider whether or not the provider has been given notice of prior violations of this rule or other program policies. If the provider has received notice and has failed to correct the deficiencies or has resumed the deficient performance, a history shall be given substantial weight supporting the agency's decision to invoke sanctions. If the history includes a prior imposition of sanction, the agency should not apply a lesser sanction in the second case, even if the subsequent violations are of a different nature;

4. Prior imposition of sanctions The Medicaid agency shall consider more severe sanctions in cases where a provider has been subject to sanctions by the Missouri Medicaid program, any other governmental medical program, Medicare or exclusion by any private medical insurance carriers for misconduct in billing or professional practice. Restricted or limited participation in compromise after being notified or a more severe sanction should be considered as a prior imposition of a sanction for the purpose of this subsection;

5. Prior provision of provider education In cases where sanctions are being considered for billing deficiencies only, the Medicaid agency may mitigate its sanction if it determines that prior provider education was not provided. In cases where sanctions are being considered for billing deficiencies only and prior provider education has been given, prior provider education followed by a repetition of the same billing deficiencies shall weigh heavily in support of the medical agency's decision to invoke severe sanctions; and

6. Actions taken or recommended by peer review groups, licensing boards or Professional Review Organizations (PRO) or utilization review committees—Actions or recommendations by a provider's peers shall be considered as serious if they involve a determination that the provider has kept or allowed to be kept, substandard medical records, negligently or carelessly performed treatment or services, or, in the case of licensing boards, placed the provider under restrictions or on probation.

(B) Where a provider has been convicted of defrauding any Medicaid program, has been previously sanctioned due to program abuse, has been terminated from the Medicare program, the Medicaid agency shall terminate the provider from participation in the Medicaid program.

(C) When a sanction involving the collection, recoupment or withholding of Medicaid payments from a provider is imposed on a provider, it shall become effective ten (10) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. When any other sanction is imposed on a provider it shall become effective thirty (30) days from the date the provider receives notice established by a signed receipt of delivery of the imposition of the sanction. If, in the judgment of the single state agency, the surrounding facts and circumstances clearly show that serious abuse or harm may result from delaying the imposition of a sanction, any sanction may be made effective immediately upon receipt of notice by the provider.

(D) A sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure or inadequacy of performance may be imputed to an affiliate when the affiliate knew or should have known of the provider's actions.

(E) Suspension or termination of any provider shall preclude the provider from participation in the Medicaid program, either personally or through claims submitted by any clinic, group, corporation or other association to the single state agency or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(F) No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the single state agency or its fiscal agents for any services or supplies provided by, or under the supervision of, a person within the organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination.

(G) When the provisions of the previously mentioned are violated by a provider of services which is a clinic, group, corporation or other association, the single state agency may suspend or terminate the organization, the individual person, or both, within the organization who knew or should have known of the violation.

(H) When a provider has been sanctioned, the single state agency shall notify, as appropriate, the applicable professional society, board of registration or licensure, federal and state agencies of the finding made and the sanctions imposed.

(I) Where a provider's participation in the Medicaid program has been suspended or terminated, the single state agency shall notify the county offices of the suspensions or terminations.

(J) Except where termination has been imposed, a provider who has been sanctioned may be required to participate in a provider education program as a condition of continued participation. Provider education programs may include:

1. Telephone and written instructions;
2. Provider manuals and workshops;
3. Instruction in claim form completion;
4. Instruction on the use and format of provider manuals;
5. Instruction on the use of procedure codes;
6. Key provisions of the Medicaid program;
7. Instruction on reimbursement rates; and
8. Instruction on how to inquire about coding or billing problems.

(K) Providers that have been suspended from the Missouri Medicaid program under subsections (3)(B) and (C) may be reenrolled in the Medicaid program upon expiration of the period of suspension from the program after making satisfactory assurances of future compliance. Providers that have been terminated from the Missouri Medicaid program under subsection (3)(B) may be reenrolled in the program at the sole discretion of the single state agency and only after providing satisfactory evidence that the past cause for termination has ceased and that future participation is warranted.

(5) Amounts Due the Department of Social Services From a Provider.

(A) If there exists an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. If the amount due is not sooner paid to the Department of Social Services by or on behalf of the provider, the single state agency, forty-five (45) days from the date the provider receives the notice, established by a signed receipt of delivery, may take appropriate action to collect the overpayment. The single state agency may recover the overpayment by withholding from current Medicaid reimbursement. The withholding may be taken from one (1) or more payments until the funds withheld in the aggregate equal the amount due as stated in the notice.

(B) When a provider receives notice, established by a signed receipt of delivery, of an overpayment and the amount due is in excess of one thousand dollars ($1000), the provider, within ten (10) days of the notice, may submit to the single state agency a plan for repayment of forty percent (40%) of the overpayment amount and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. No repayment plans will be considered for the first sixty percent (60%) of the overpayment amount. If this repayment plan is timely received from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within ten (10) days after the proposal is received. If no plan for repayment is agreed upon within thirty (30) days after the provider receives notice of the overpayment, the Medicaid agency may take appropriate action to collect the balance of the amount due.

(C) If a plan agreed to and implemented under provisions of subsection (5)(B) for repayment of amounts due the Department of Social Services from a provider is breached, discontinued or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, may begin to withhold payments or portions of payments until the entire amount due has been collected.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

AUTHORITY: section 208.201, RSMo Supp. 1987. This rule was previously filed as 13 CSR 40-81.160. Original rule filed Sept. 22, 1979, effective Feb. 11, 1980. Amended: Filed Nov. 25, 1981, effective March 11, 1982. Emergency amendment filed April 14, 1982, effective April 24, 1982, expired July 10, 1982. Amended: Filed April 14, 1982, effective July 11, 1982. Amended: Filed April 16, 1985, effective Sept. 1, 1985. Emergency amendment filed Dec. 5, 1986, effective Dec. 15, 1986, expired April 13, 1987. Amended: Filed Dec. 16, 1986, effective April 11, 1987. Amended: Filed Jan. 7, 1987, effective April 26, 1987. Emergency amendment filed April 15, 1988, effective April 25, 1988, expired Aug. 22, 1988. Amended: Filed June 2, 1988, effective Aug. 25, 1988. Amended: Filed Aug. 2, 1990, effective Feb. 14, 1991. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency amendment filed April 15, 1994, effective April 30, 1994, expired Aug. 13, 1994. Amended: Filed Feb. 16, 1994, effective Aug. 28, 1994.*

**Original authority 1987.*

13 CSR 70-3.040 Duty of Medicaid Participating Hospitals and Other Vendors to Assist in Recovering Third-Party Payments

PURPOSE: This rule places a certain duty on Medicaid participating hospitals and other vendors to assist the Division of Family Services in making Medicaid third-party liability recoveries.

(1) All Medicaid participating hospitals or other vendors who have received reimbursement under Medicaid (Title XIX), or have made claim or anticipate making a claim for reimbursement, and who shall receive a request from an attorney or insurance carrier for medical or other information pertaining to the Medicaid recipient for whom reimbursement has been received or claim made shall inform the attorney or insurance carrier that the Division of Family Services has the duty under section 208.153, RSMo to seek reimbursement from any source contractually or legally obligated to be primarily responsible to pay any moneys to or on behalf of the Medicaid recipient.

AUTHORITY: section 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.090. Original rule filed May 20, 1977, effective Sept. 11, 1977.*

**Original authority 1967, amended 1967, 1973, 1989, 1990, 1991.*

13 CSR 70-3.050 Obtaining Information From Providers of Medical Services

PURPOSE: This rule provides the basis for examination of the records of any provider who expects to receive payment from the Division of Family Services and for maintaining the confidentiality of any of those records.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Public Law 89-97, 1965 Amendment to the Social Security Act (42 U.S.C.A. Section 301), sections 201.151 and 208.153, RSMo, and other pertinent sections of Chapter 208, RSMo require Missouri to provide certain medical services to eligible individuals and further provide that these services may be obtained from any provider who has entered into an agreement for provision of medical services with the Missouri Division of Family Services. Therefore, to aid the Division of Family Services in determining the proper and correct payment for those services, the acceptance of these medical services and benefits by any applicant or recipient of public assistance benefits constitutes authorization for the Division of Family Services, or its duly authorized representative, to examine all records pertaining to medical services provided the applicant or recipient in order that proper payment for the services may be made to the provider of services.

(2) Section 208.155, RSMo, regarding the confidentiality of all information concerning applicants for or recipients of medical services shall be confidential, shall be strictly adhered to.

AUTHORITY: section 207.020, RSMo Supp. 1993. This rule was previously filed as 13 CSR 40-81.060. Original rule filed Sept. 29, 1975, effective Oct. 9, 1975.*

**Original authority 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993.*

13 CSR 70-3.060 Medicaid Program Payment of Claims for Medicare Part B Services
(Rescinded August 11, 1988)

AUTHORITY: sections 208.153, RSMo 1986 and 208.201, RSMo Supp. 1987. Original rule filed March 2, 1988, effective May 12, 1988. Emergency rescission filed April 29, 1988, effective May 9, 1988. Rescinded: Filed May 17, 1988, effective Aug. 11, 1988.

13 CSR 70-3.100 Filing of Claims, Medicaid Program

PURPOSE: This rule establishes the general provisions for submission or resubmission of claims and adjustments of claims to Missouri Medicaid.

(1) Claim forms used for filing Medicaid services as appropriate to the provider of services are—
(A) Nursing Home Claim—MO-8804, Revision 04/88;
(B) Pharmacy Claim—MO-8803, Revision 04/88;
(C) Outpatient Hospital Claim—UB-92 HCFA-1450;
(D) Professional Services Claim—HCFA-1500, Revision 12/90;
(E) Dental Claim—MO-8802, Revision 04/88; or
(F) Inpatient Hospital Claim—UB-92 HCFA-1450;

(2) Reference the appropriate provider manual and claim filing instructions for specific claim filing instructions information.

(3) Time Limit for Original Claim Filing. Claims from participating providers that request Medicaid reimbursement must be filed by the provider and received by the state agency within twelve (12) months from the date of service. The counting of the twelve (12)-month time limit begins with the date of service and ends with the date of receipt.
(A) Claims that have been initially filed with Medicare within the Medicare timely filing requirement and which require separate filing of a paper claim with Medicaid will meet timely filing requirements by being submitted by the provider and received by the state agency within twelve (12) months of the date of service or six (6) months of the date on the Medicare provider's notice of the disposition of the claim.
(B) Claims for recipients who have a third-party resource that is primary to Medicaid must be submitted to the third-party resource for adjudication unless otherwise specified by the Division of Medical Services. Documentation specified by the Division of Medical Services which indicates the third-party resource's adjudication of the claim must be attached to the claim filed for Medicaid reimbursement. If the Division of Medical Services waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the Medicaid timely filing requirement by being filed by the provider and received by the state agency within twelve (12) months from the date of service.

(4) Time Limit for Resubmission of a Claim After Twelve (12) Months From the Date of Service.
(A) Claims which have been originally submitted and received within twelve (12) months from the date of service and denied or returned to the provider may be resubmitted within twenty-four (24) months of the date of service. Those claims must be filed by the provider and received by the state agency within twenty-four (24) months from the date of service. The counting of the twenty-four (24)-month time limit begins with the date of service and ends with the date of receipt.
(B) Documentation specified by the Division of Medical Services in Medicaid provider manuals which indicates the claim was originally filed timely must be attached to the resubmission.
(C) Claims will not be paid when filed by the provider and received by the state agency beyond twenty-four (24) months from the date of service.

(5) Denial. Claims that are not submitted in a timely manner as described in sections (1) and (2) of this rule will be denied. Except that at any time in accordance with a court order, the agency may make payments to carry out hearing decision, corrective action or court order to others in the same situation as those directly affected by it. The agency may make payment at any time when a claim was denied due to state agency error or delay, as determined by the state agency.

(6) Time Limit for Filing an Adjustment. Adjustments to a paid claim must be filed within eighteen (18) months from the date of payment.

(7) Definitions.
(A) Claim A—claim is each individual line item of service on a claim form, for which a charge is billed by a provider, for all claim form types except inpatient hospital. An inpatient hospital service claim is all the billed charges contained on one (1) inpatient claim document.
(B) Date of payment/denial–The date of payment or denial of a claim is the date on the remittance advice at the top center of each page under the words remittance advice.
(C) Date of receipt—The date of receipt of a claim is the date the claim is received by the state agency. For a claim which is processed, this date appears as a Julian date in the internal control number (ICN). For a claim which is returned to the provider, this date appears on the Return to Provider form letter.
(D) Date of service—The date of service which is used as the beginning point for determining the timely filing limit applies to the various claim types as follows:
1. Nursing home—The through date or ending date of service for each line item for each individual recipient listed on the Turn-Around Document;
2. Pharmacy—The date dispensed for each line item for each individual recipient listed on the claim form;
3. Outpatient hospital—The ending date of service for each individual line item on the claim form;
4. Professional services (HCFA-1500)—The ending date of service for each individual line item on the claim form;
5. Dental—The date service was performed for each individual line item on the claim form;
6. Inpatient hospital—The through date of service in the area indicating the claimed period of service; and
7. For service which involves the providing of dentures, hearing aids, eyeglasses or items of durable medical equipment; for example, artificial larynx, braces, hospital beds, wheelchairs, the date of service will be the date of delivery or placement of the device or item.